Technology-Assisted Waiver

KanCare HCBS Waiver
KDADS
Presented by: Children's Resource Connection

TA Waiver Mission

- Provide hospital-level of care in an in-home setting so children can remain with their family instead of a hospital or institution.
- Provide the necessary in-home nursing services that can maintain or actually improve the child's medical status, as well as educate parents in child's care.
- Provide care support for families to allow parents to seek and/or maintain employment to help support the family unit.
- Services individuals age 0 thru 21 years of age.

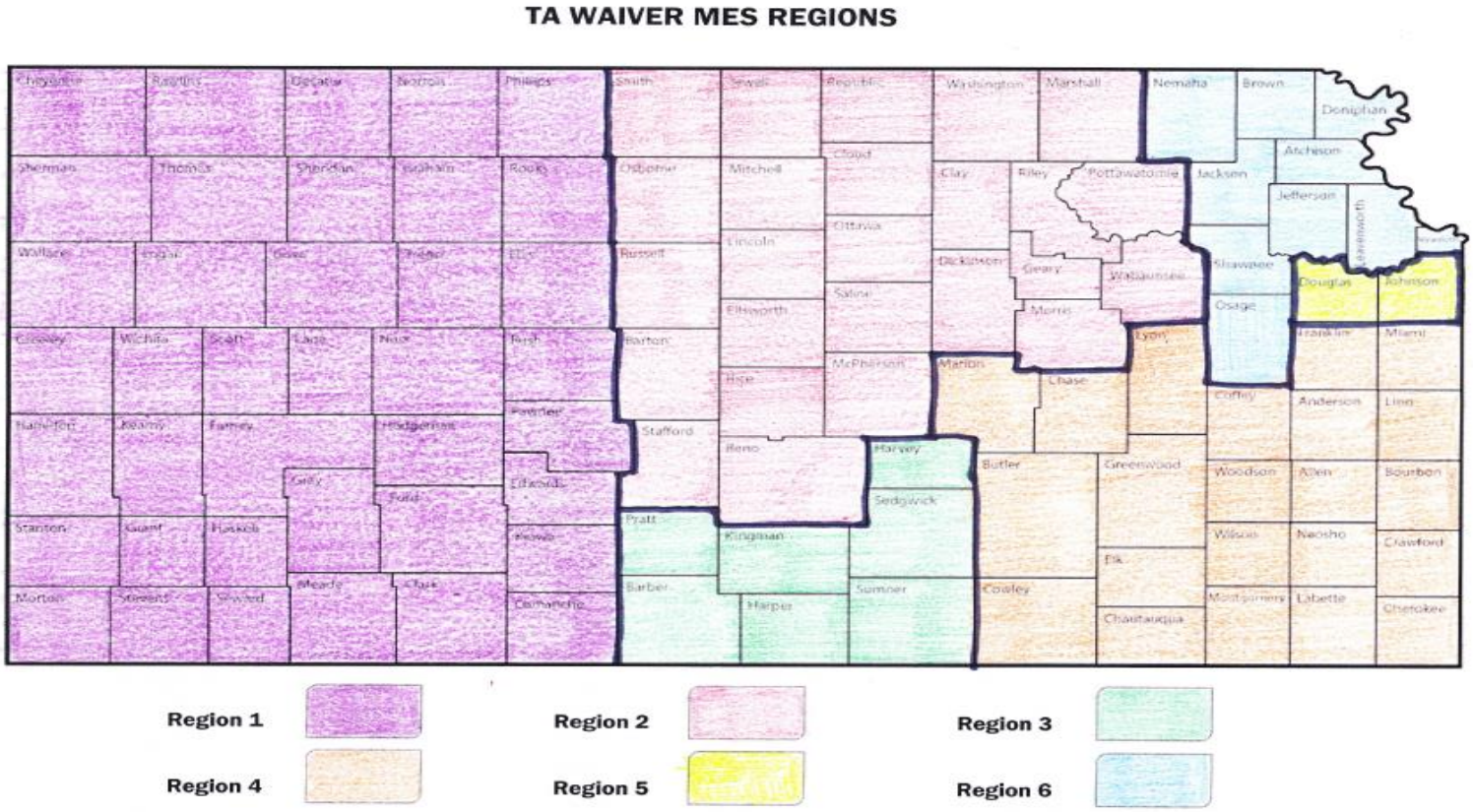
TA Waiver

Definition of Technology Assisted and Medically Fragile

- Technology Assisted
  - Dependent on an eligible medical device to compensate for loss of vital body function.
  - Require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting, to avert death or further disability.
  - In the absence of home care, illness or disability would require admission to, or prolonged stay in a hospital.

TA Waiver Overview

- MATLOC assessment tool evaluates the type of medical technology dependency and level of medical fragility of the individual.
- Administered by a trained and State certified RN or APRN.
- MES brings years of experience working with disabled children, as well as families and trauma situations. There are 4 assessors that cover the entire State of Kansas, with the State divided into 6 regions.



MATLOC Eligibility Specialists

Monique Barnes, RN, MSN, APRN

Toby Leavendusky, RN, BSN

Kipp Wilhoit, RN, BSN

Susan Hellman, RN, BSN – Children's Choice

TA Waiver Eligible Technologies

- Total or Intermittent Ventilator dependent
- Tracheostomy
- Bi-Pap or C-Pap
- Oxygen – continuous greater than 8 hrs
- Oximetry or Apnea Monitor – continuous greater than 8 hrs and in conjunction with the oxygen technology requirement
- Gastro tube feeding – either continuous or bolus, providing majority of nutritional intake, not supplemental
- Total Parental Nutrition (TPN) – continuous greater than 6 hrs
- Intravenous (IV) Therapy – continuous greater than 6 hrs
- Home Dialysis (must be administered in the home)

TA Waiver
Additional Eligibility Criteria

- In addition to meeting definition of “technology assisted”, the individual must also meet the following criteria:
  - Require daily use of eligible technology device and meet the minimum technology points requirement.
  - Meet the level of care (LOC) minimum nursing acuity threshold for the specific age group.
  - Must be a Kansas resident and provide proof of US citizenship.
  - Be determined eligible for Medicaid.

TA Waiver
Referral Process

- Children's Resource Connection
  - The one-stop referral center for TA Waiver.
  - Communications with hospitals all over Kansas, as well as DCF offices, providers, Infant-Toddler services, as well as hospitals out of state that handle our demographics.
  - Good communications with all 3 MCOs.
  - Experienced in working with the TA population.

TA Waiver
Referral Process

- New Referrals
  - After initial screening, if child meets the technology requirements, the case is assigned to the MATLOC Eligibility Specialist (MES) who covers the region where they live.
  - MES contacts family within 24 business hours and arranges a time to conduct the initial assessment.
  - Assessment to be conducted within 5 to 10 days of referral, if possible. Can be done as early as 14 days before hospital discharge.

TA Waiver
Referral Process

- New Referrals
  - If child is found eligible, CRC processes the assessment done by MES and submits it to the KAMIS database. TA Waiver does not need Program Manager approval as assessment tool is the medical technology and acuity indicator and there is no wait list for the TA Waiver.
  - CRC notifies the assigned MCO of TA eligibility through Notice of Action. Follows up on child's coding status to make sure the 3160 form is processed and required documentation is submitted by family.
  - If child is not active in KanCare, coding status is followed up with DCF to make sure required documentation has been received and MCO notified once coding is complete.

TA Waiver
Required Eligibility Reassessments

- 6-mo Reassessments
  - Eligibility reassessments are conducted on active TA Waiver children every 6-months.
  - If a child is found to no longer be eligible, but still has qualifying technology, a period of 45 days is given before eligibility ends. MCO should assist with either transition to another waiver or locate community services.
  - If a child loses eligible technology at any time, a period of 10 days is give before TA eligibility ends.

MATLOC Eligibility Assessment Tool

Medical Assistive Technology Level of Care

Kansas Department for Aging and Disability Services
Community Services and Programs

HCBS-Technology Assisted Waiver

Medical Assistive Technology Level of Care Instrument
(MATLOC)

Section: I (Child's Demographics Information)

				Medicaid #:
Last Name:		**First Name:**		**DOB:**
Parent or Guardian:			**Last KBH:**	**SS#:**
Address:	**City:**	**State: KS**	**Zip:**	**County:**
Home Phone:	**Work Phone:**		**Cell Phone:**	
Primary Insurance:	**Group#:**		**Effective Date:**	**Decline Date:**

Alternative Mailing Address

Foster Home Placement: N/A	**Address:**	**City:**	**State: KS Zip:**

Personal Information

Gender: Unknown	**Primary Language:** Unknown	**Specify Other:**	
Referral Agency: N/A **Date:**	**Hometown:** N/A	**Attends School?** N/A	**Ethnicity:** Other

Assessment Completion

Type of Assessment	☐ **New** (initial LOC assessment)	☐ **Modified**	☐ **Reassessment** (every 6 mos. or as needed)
Date of Assessment			

Diagnosis

Primary Diagnosis	**Diagnosis Code**	**Secondary Diagnosis**	**Diagnosis Code**

(Level of Care Eligibility Assessment)

CURRENT MEDICAL TECHNOLOGY	**POINT VALUE**	**REFERRAL FOR WAIVER SERVICE** (MATLOC ELIGIBILITY SPECIALIST SECTION)
Ventilator: Intermittent ☐	☐ 40	**KanCare Health Plan of Choice:**
Ventilator: Total ☐	☐ 50	
Tracheostomy ☐ (do not check if total vent is selected)	☐ 40	**Level of Care Requested**
C-Pap ☐ Bi-Pap ☐	☐ 25	☐ LPN
O2(cont. over 8hrs.): (required for apnea monitor and/or oximetry points)	☐ 20	☐ RN
Oximetry(cont over 8hrs.) ☐ Apnea Monitor(cont over 8hrs.) ☐	☐ 10	☐ Personal Service Attendant
Gastro-tube cont.☐ bolus☐ :	☐ 35	☐ Medical Service Technician
(TPN) or (IV) Therapy (cont. over 6 hrs.) ☐	☐ 40	
Home Dialysis* (see qualifier)	☐ 40	
*** **Special Treatments (provided at min. 4x daily)** ☐ **Specify:**	☐ 10	
Level of Care assessment indicates the individual is determined functionally; ☐ eligible ☐ not eligible	**Nursing acuity points:** **Technology points:** **Total eligible support hrs:** per week	

***Special Treatments: (i.e. but not limited to;** nebulizer tx, suction, sterile dressing)
***Level of Care assessment:** Demonstrates an individual's level of care based on the combined medical technology and nursing acuity.
* **Nursing Acuity points:** Represents the amount of time for each care element per week.
* **Number of eligible formal support:** Calculation (total nursing acuity points/7x31= eligible formal support per month).

MATLOC Eligibility Specialist's Information

Name	**Title**	**Agency**	**Provider Number**	**Phone**
Date of application submission:		**DCF Worker:**		

Section: II (Nursing Acuity Scale I)

Last Name:	First Name:	DOB:	Medicaid#:

Point	Care Element	Point	Care Element	Point	Care Element
	Weight .5 ☐ < 65lbs. no or partial lift 1 ☐ > 65lbs. no or partial lift 1 ☐ < 55lbs. total lift 2 ☐ > 55lbs. total lift 2.5 ☐ > 125lbs. partial or total lift		***Mobility*** 1 ☐ Back brace 1.5 ☐ Fracture or cast- UE 2 ☐ Fracture or cast- LE 2 ☐ Body cast 1.5 ☐ Missing limb 1.5 ☐ Short/dysfunctional limb .5 ☐ AFOs/ splints/ orthotics 1 ☐ OT/PT daily regiment 2 ☐ Walker/WC/Crutch dep. 1 ☐ ROM 1.5 ☐ Turn q 2h 1 ☐ Lift device .5 ☐ Special positioning		***Elimination*** .5 ☐ Incont. stool occasionally 1.5 ☐ Incont. stool daily .5 ☐ Incont. urine occasionally .5 ☐ Incont. urine daily 1 ☐ Trip training bowel/bladder 2 ☐ Total assist perineal care 1 ☐ Urinary catheter indwelling 1 ☐ Ileostomy/Colostomy 1.5 ☐ Straight catheter 10 ☐ Home Dialysis*
	Nutrition 1 ☐ Special diet or prolonged oral feeding 1.5 ☐ Reflux/ dysphagia 1.5 ☐ NG-tube 1 ☐ G-tube 1 ☐ Enteral pump .5 ☐ Gravity				
	Integumentary 1 ☐ Stoma/ ostomy care 1.5 ☐ Wound care general 2 ☐ Decubitus care 2 ☐ Burn care 2 ☐ Complex dressing 1 ☐ Skin treatment > q4h		***Neurologic*** (seizures) 1 ☐ Mild, min. management 1.5 ☐ Mod., medication admin 1 ☐ Intervene>3x/wk 1.5 ☐ Intervene daily 2 ☐ Severe, meds/airway/injury 1 ☐ VNS>3x/wk		***Sleep*** .5 ☐ Sleep< 8hrs/noc 1 ☐ Sleep<6hrs/noc 1.5 ☐ Sleep<4hrs/noc 2 ☐ Sleep<2hrs/noc
	Communication (see last page for more) 1.5 ☐ Communication limited (difficulty communicating needs), is expressive/receptive/ augmented 2 ☐ Non-verbal (unable to communicate)		**MES Comments:**		

Total points :

Click on the boxes in front of the applicable care element, tabulate and assign points.

Section II: (Nursing Acuity Scale II)

Last Name:	First Name:	DOB:	Medicaid#:

Point	Care Element	Point	Care Element	Point	Care Element
	Hydration/ Specialty Care 2 ☐ IV therapy<q4h 1.5 ☐ IV therapy>q4h 2 ☐ **IV therapy cont> 6 hrs** 1.5 ☐ IV therapy intermittent 2.5 ☐ TPN central line 2 ☐ Central line care 1 ☐ Blood product admin q month 2 ☐ IV pain control 1 ☐ Lab draw each peripheral 1.5 ☐ Lab draw each central 2 ☐ Chemotherapy IV or injection .5 ☐ Maintain infusion port .5 ☐ Finger sticks		***Airway Management*** 1 ☐ Tracheostomy 1 ☐ **Oxygen, continuous** .5 ☐ **Oxygen, intermittent** .5 ☐ Oxygen prn .5 ☐ Humidification .5 ☐ Intermit. oronasal suctioning 1 ☐ Occasional tracheal suctioning 1.5 ☐ Tracheal suctioning >q3hrs. 2 ☐ **Bi-Pap or C-pap** 3.5 ☐ Ventilator 10 ☐ Respiratory effort absent 2 ☐ SIMV<10hrs/day 3 ☐ SIMV>10hrs/day 1 ☐ Vent on standby 2 ☐ Respiratory assist mode 1 ☐ Aspiration precaution 1.5 ☐ Apnea 1 ☐ Cont. apnea/oximetry monitor 1 ☐ Cough assist/percussion daily .5 ☐ Nebulizer>q4h		***Orientation/Behaviors/ Cognition*** .5 ☐ Oriented<X3 1 ☐ Confused 2 ☐ Cognitive impaired-dependent/ Uncooperative 1.5 ☐ Cognitive impaired-ADL interference 1.5 ☐ Combative .5 ☐ Requires occasional redirection 1 ☐ Requires frequent redirection 1 ☐ Self-abusive behavior, mild-no injury. 1.5 ☐ Self-abusive behavior, moderate injury 2 ☐ Self-abusive behavior, Severe
	Assessments 1 ☐ General assessment q shift 1.5 ☐ Intermittent assess (mod) 2 ☐ Continual assess. Line of sight 1 ☐ Min. 3hrs/wk RN manager intervention (Lab, MD contact, care planning) 2 ☐ >3hr/wk RN manager intervention .5 ☐ Assess VS/neuro/resp/GI q8h 1 ☐ Assess VS/neuro/resp/GI q4h 1.5 ☐ Assess VS/neuro/resp/GI q2h or less				
	Development .5 ☐ Development delay<5yrs. 1 ☐ Developmental disability 5+ years old(biological age)		***Sensory Deficits*** .5 ☐ Visual .5 ☐ Auditory .5 ☐ Tactile		***Medication Administration*** 1 ☐ Injectable med<1x wk 1.5 ☐ Injectable med>1xwk 1.5 ☐ Complex med admin, and/or RX>q2hr intervals 1 ☐ Routine Medication Admin.
	Acute Care Episodes (select one only) 1.5 ☐ Acute hospitalization> 7 days 2.5 ☐ New trach within 30 days 1.5 ☐ Abdominal surgery within 45 days 1.5 ☐ Bone surgery within 45days 2.5 ☐ Ventricular shunt new or revised within 30 days.		**MES Comments:**		
Total points (add rows):					

Section II: (Nursing Acuity Scale III)

Last Name:	First Name:	DOB:	Medicaid#:

Communication Level (If eligible, 2 points total awarded)

Hearing

- ☐ 0- Hears adequately
- ☐ 1- Minimal difficulty
- ☐ 2- Hears in special situation only
- ☐ 3- Highly impaired/absence of useful hearing

Making Self Understood

- ☐ 0- Understand
- ☐ 1- Usually understood- difficulty finding words or finishing thoughts
- ☐ 2- Sometimes understood- ability is limited to making concrete requests
- ☐ 3- Rarely/never understood

Speech Clarity

- ☐ 0- Clear speech
- ☐ 1- Unclear speech-slurred mumbled words
- ☐ 2- No speech- absence of spoken words
- ☐ 3- Unable to make needs know by any means

Ability to Understand

- ☐ 0- Understands
- ☐ 1- Usually understands-may miss some part/intent of message
- ☐ 2- Sometimes understands- responds adequately to simple, direct communication
- ☐ 3- Rarely/ never understands

Modes of Expression (Indicate which one)

- ☐ Speech
- ☐ Signs/gesture/sounds
- ☐ Writing
- ☐ Communication board
- ☐ American Sign Language or Braille
- ☐ Dynavox or other device

Communication Devices/ Techniques

- ☐ Hearing aid
- ☐ Other receptive techniques used(e.g. lip reading)

Mood (indicate which one)

- ☐ Positive
- ☐ Anxious
- ☐ Depressed
- ☐ Calm
- ☐ Tearful
- ☐ Suicidal

*Click on the boxes in front of the applicable level of communication.

* If rated 3 or more in any of the levels of communication category, add 2 points to the grand total

Total additional points:

Total points Acuity Scale I	Total points Acuity Scale II	Total points Acuity Scale III	Total eligible service hours based on medical needs assessment
hours	hours	N/A hours	hours per month

***The total number of nursing acuity points assessed for each acuity scale section represents the number of eligible service hours for the care element selected in the corresponding category.*

My signature acknowledges and confirms the accuracy of the Medical Assistive Technology Level of Care assessment, including my choice of KanCare Health Plan as indicated on page 1 of this assessment. I agree the assessment is current and true as of date.

Child/Parent/Guardian Signature: ☐ Original on file Date:

MATLOC Eligibility Specialist (MES) Signature/ Title: ☐ Original on file Date:

My signature confirms the individual being assessed is under my care; and the medical technology needs and care elements identified in this assessment is accurate and true to the best of my knowledge.

Medical Provider Signature: ☐ Original on file Date:
(Attending Physician, PA, ARNP)

Kansas Department for Aging and Disability Services
Community Services and Programs
HCBS-Technology Assisted Waiver
Participant Service Plan of Care (PSPOC)

Name:	DOB:	Medicaid#:
Level of Care Assessment: ☐ Initial ☐ Modified ☐ Reassessment	Date of assessment:	Assessment period: -

Type of Service Plan: ☐ Expedited (*check for initial LOC assessment only*) ☐ Estimated Service Plan (*check for initial and LOC reassessment*)

In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act. All individual determined level of care eligible for the waiver may choose any or all services offered under the waiver. All service(s) requested will be considered based on individual and family medical needs, requested services requires prior authorization and are subject to approval by the participant's KanCare Health Plan of choice.

Section I: Service Delivery History

Current KanCare Health Plan Provider	What type of service does the participant currently receive? (check all that applies)	***Consideration for additional support beyond assessed medical needs:***
☐ Amerigroup ☐ Sunflower State Health Plan ☐ United Healthcare ☐ New to KanCare	☐ Interm. Intensive Medical Care (IIMC) ☐ Specialized Medical Care (SMC) ☐ Agency (MST) ☐ Self-directed (PSA) ☐ Medical Respite (MR-SMC) ☐ Health Maintenance Monitoring (HMM) ☐ Home Modification Services (HMS)	

Section II: Risk Factors: **Calculation (risk factor total= x31days= /mo.)*

	Total Eligible Support
3 ☐ **Single parent working outside home** 1 ☐ **One parent work outside home** 2 ☐ **Two parent work outside home** 3 ☐ **Other special needs/TA child in home, how many?** 2 ☐ **Current or recent problem within the last month of neglect, abuse, or exploitation experience** 2 ☐ **Parent of 2 or more non-school age child(ren)** 1 ☐ **Lives in rural demographic region** 1 ☐ **Cultural/ language barriers**	A. Total eligible formal support hrs based on nursing acuity needs: /mo. B. Total eligible risk factors hrs: /mo. C. Expedited Care (six weeks)- do not complete section III (1-6) of this form ☐ 24hr/day X 7 days (week 1) ☐ 18 hr/day X 7 days (week 4) ☐ 22hr/day X 7 days (week 2) ☐ 16hr/day X 14 days (week 5&6) ☐ 20hr/day X 14 days (week 3)

Note** Section II-C (Expedited Care is available to post-hospital discharge at initial level of care assessment only)

Section III: Proposed Service Plan (Include formal and informal support)

1) Type of service	**2) Total formal support**	**3) Time of day**	**4) Total hours per day of informal and formal supports**						
Level of care needs/ Current provider or agency of choice	Hrs/mo	Start-End Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
N/A:	/mo	-							
N/A:	/mo	-							
N/A:	/mo	-							
N/A:	/mo	-							
5) **Total formal support hours requested:** /mo		***Support hours calculation= # eligible hours/31 days= daily average, *Do not include respite**							
6) **Total formal support units requested:** /mo									

1) Indicate type of support /Name of provider or Agency of choice(s). 2) Indicate total eligible formal support requested for each waiver service per month. 3) Indicate when formal/informal support will be delivered. 4) Total formal/informal support hours per day. 5) Total eligible formal hours of service requested per month. 6) Total eligible formal units requested per month.

I, on behalf of have chosen to participate in Home and Community Based- TA Waiver Program as an alternative to hospitalization. I participated in the development of this service plan and I understand my KanCare Health Plan will assist me with access to needed waiver service(s) and service provider(s). My signature acknowledges my authorization and agreement with the information provided and submitted on this service plan.

Participant/Parent/Legal Representative Signature: , Date: ☐ Original on file

MATLOC Eligibility Specialist Signature/Title: , Date: ☐ Original on file

TA Waiver Population

- As of 12/31/14, there were 427 children actively receiving TA Waiver services.
- The TA Waiver averages over 15 new referrals every month with 170 new children added in 2014.
- Adding in new referrals and children found ineligible for services, or who expired, approximately 620 children were evaluated and/or received services in 2014.
- Total assessments (initial and 6-mo) conducted in 2014 were 1016.

TA Waiver

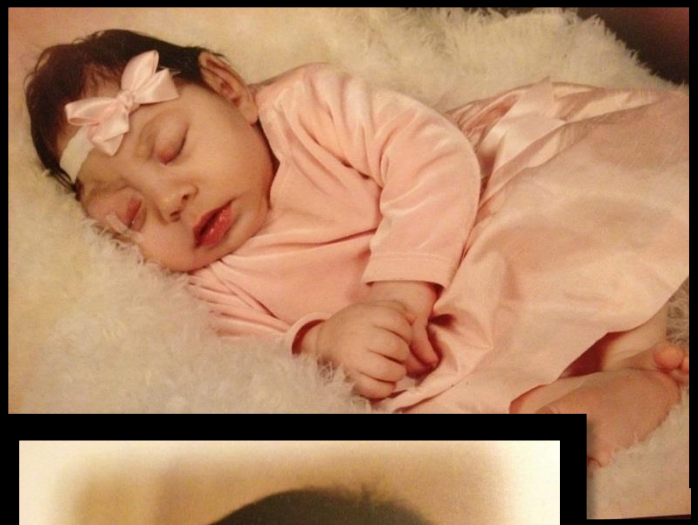
- CRC and the MES are committed to ensuring that children meet the eligibility requirements set out by the State of Kansas before being placed on or remaining on the TA Waiver and receive in-home nursing and/or attendant care.
- A success story for a child on the TA Waiver is to be able to transition off services (either to another waiver or community services) because as a result of having in-home nursing care, and the parental education and training of care, their medical status has improved to where there are no longer considered to be medically fragile and have declined in their medical acuity needs, or are no longer dependent on technology.

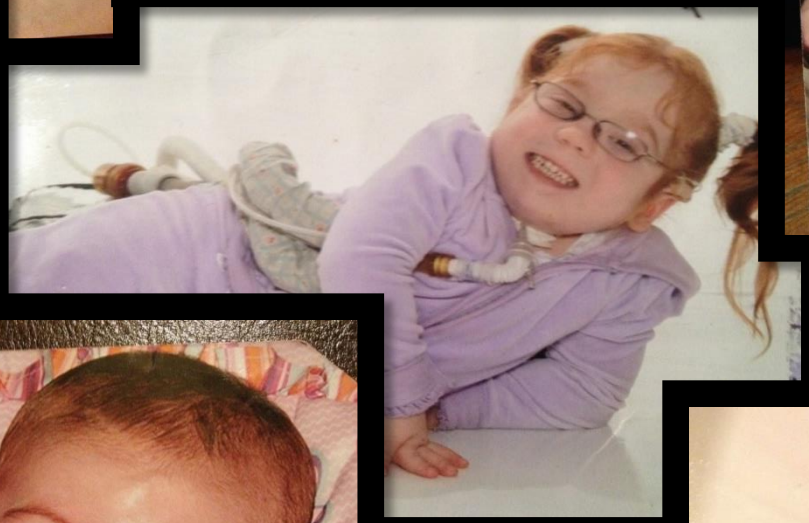
TA Waiver

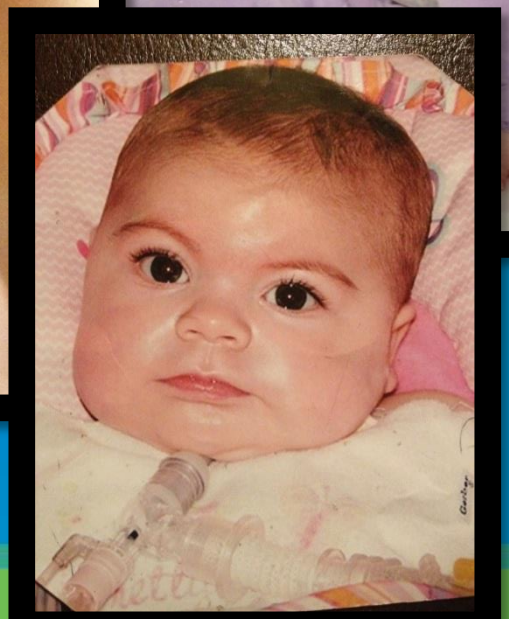
- CRC and the eligibility assessors have no connection to any MCO or service provider, thus providing a conflict-free environment when completing eligibility assessments.
- It is advantageous to the integrity of the TA Waiver, being a medical waiver, that all assessments are conducted by a RN or APRN who is knowledgeable about medical equipment, needs, medications, conditions, etc., so that appropriate medical evaluations of needs are accomplished.

KDADS Home and Community Based Services

Technology Assisted Waiver







TA Waiver Kids